FRAMEWORK FOR ANNUAL REPORT OF STATE CHILDREN'S HEALTH INSURANCE PLANS UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

Preamble

Section 2108(a) of the Act provides that the State must assess the operation of the State child health plan in each fiscal year, and report to the Secretary, by January 1 following the end of the fiscal year, on the results of the assessment. In addition, this section of the Act provides that the State must assess the progress made in reducing the number of uncovered, low-income children.

To assist states in complying with the statute, the National Academy for State Health Policy (NASHP), with funding from the David and Lucile Packard Foundation, has coordinated an effort with states to develop a framework for the Title XXI annual reports.

The framework is designed to:

- Recognize the ***diversity*** of State approaches to SCHIP and allow States ***flexibility*** to highlight key accomplishments and progress of their SCHIP programs, **AND**

- Provide ***consistency*** across States in the structure, content, and format of the report, **AND**

- Build on data ***already collected*** by HCFA quarterly enrollment and expenditure reports, **AND**

- Enhance ***accessibility*** of information to stakeholders on the achievements under Title XXI.

FRAMEWORK FOR ANNUAL REPORT
OF STATE CHILDREN'S HEALTH INSURANCE PLANS
UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

State/Territory: State of Indiana

The following Annual Report is submitted in compliance with Title XXI of the Social Security Act (Section 2108(a)).

(Signature of Agency Head)

SCHIP Program Name (s): Hoosier Healthwise for Children

SCHIP Program Type
____ Medicaid SCHIP Expansion Only
____ Separate SCHIP Program Only
__X__ Combination of the above

Reporting Period: **Federal Fiscal Year 2000 (10/1/99-9/30/00)**

Contact Person/Title: Kathryn Moses, Policy Analyst

Address: 402 West Washington Street, Room W382
Indianapolis, Indiana 46202

Phone: 317/232-4390
Fax: 317/232-7382
E-mail: kmoses@fssa.state.in.us

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SECTION 1. DESCRIPTION OF PROGRAM CHANGES AND PROGRESS

This section has been designed to allow you to report on your SCHIP program's changes and progress during Federal fiscal year 2000 (September 30, 1999 to October 1, 2000).

1.1 Please explain changes your State has made in your SCHIP program since September 30, 1999 in the following areas and explain the reason(s) the changes were implemented.

Note: If no new policies or procedures have been implemented since September 30, 1999, please enter "NC" for no change. If you explored the possibility of changing/implementing a new or different policy or procedure but did not, please explain the reason(s) for that decision as well.

1. Program eligibility – Program eligibility was increased to children in families with incomes from 150% FPL to 200% FPL with the introduction of Hoosier Healthwise Package C, Children's Health Plan (Indiana's state-designed S-CHIP program) on January 1, 2000. To be eligible for this program, the family must also agree to cost sharing and cannot have other creditable insurance.

2. Enrollment process - NC

3. Presumptive eligibility - NC

4. Continuous eligibility - NC

5. Outreach/marketing campaigns – A television/radio campaign was rolled out in early spring of 2000 to promote Hoosier Healthwise and raise awareness of how to enroll in the program. The marketing campaign was a great success, as it introduced a memorable jingle for the phone number to the Hoosier Healthwise Helpline for enrollment materials.

6. Eligibility determination process – Potential members in Hoosier Healthwise Package C are found conditionally eligible until the first premium has been paid.

7. Eligibility redetermination process - NC

8. Benefit structure – The benefits for the new, state-designed program are slightly different. (See Attachment A: CHIP Benefit Package)

9. Cost-sharing policies – Copayments for Package C are as follows: $10 for ambulance transportation, $3 for generic, compound, or sole-source drugs, $10 for brand name drugs. Premiums range from $11.00 - $24.75 per month depending on family size and income. Premiums can be paid on a monthly, quarterly, or annual basis. If the premium is paid quarterly, the family is given a 5% discount on the premium, and they receive a 10% discount if they pay on an annual basis. (See Attachment B: CHIP Cost-Sharing Requirements)

10. Crowd-out policies – If a potential Package C eligible drops their current private coverage, they must wait three months without insurance before enrolling in Hoosier Healthwise. Exceptions to this include involuntary loss of coverage (such as loss of employment) and enrollment in Medicaid.

11. Delivery system - NC

12. Coordination with other programs (especially private insurance and Medicaid) – The new state-designed program is built upon the same infrastructure as the rest of the Hoosier Healthwise program, and therefore, Medicaid. As a result, the coordination with Medicaid is virtually seamless. A work group has been formed to work on other coordination opportunities between Medicaid/CHIP and programs that provide the wrap-around services for children with special health care needs. (See Attachment C: Opportunities for Coordination in the Children's Health Programs)

13. Screen and enroll process - NC

14. Application – There is a check off box on the single Hoosier Healthwise application for applicants to mark if they agree to pay cost sharing if they are determined to be eligible for Package C. Also, they do not have to provide their social security number on the application if only applying for the state-designed program. Those applying to Package A (the Medicaid-expansion portion of CHIP) must supply their social security number. (See Attachment D: Application for Hoosier Healthwise)

15. Other - NC

1.2 Please report how much progress has been made during FFY 2000 in reducing the number of uncovered, low-income children.

1. Please report the changes that have occurred to the number or rate of uninsured, low-income children in your State during FFY 2000. Describe the data source and method used to derive this information.

   CPS data were originally used to estimate the baseline number of uninsured children. The three-year average of 1996, 1997, and 1998 CPS data suggested that there were 123,000 children in Indiana under 200% of the federal poverty level.

   However, as of September 2000 more than 144,000 children have enrolled in Hoosier Healthwise since May 31, 1998, when outreach for the Medicaid Expansion of SCHIP began. Therefore, we have enrolled more than 21,000 uninsured children above the original CPS estimate.

In response, the State commissioned a survey of the uninsured in Indiana in order to establish a better estimate of the number of uninsured children below 200% of the federal poverty level. The survey was complete as of June 2000 and indicated that 57,000 children below 200% of the federal poverty level remained uninsured. By adding these remaining uninsured children to the number of children already enrolled into the program as of June 2000 (128,386), we calculate a revised original estimate of 185,386. This reflects an adjusted maximum estimate of the original baseline number of uninsured children in Indiana. The new baseline is 57,000 uninsured children as of June 2000. Hoosier Healthwise enrollment figures are based on unduplicated, point-in-time counts on the last day of each month from Indiana's Client Eligibility System (ICES).

2. How many children have been enrolled in Medicaid as a result of SCHIP outreach activities and enrollment simplification? Describe the data source and method used to derive this information.

   As of September 30, 2000, there were 355,049 children enrolled in Hoosier Healthwise - Indiana's health insurance program for children, pregnant women, and low-income families. This represents an increase of 144,626 children since the Title XXI outreach efforts across the State began in May 1998 of whom 101,496 of these children are eligible through Medicaid. Hoosier Healthwise enrollment figures are based on unduplicated, point-in-time counts on the last day of each month from Indiana's Client Eligibility System (ICES).

3. Please present any other evidence of progress toward reducing the number of uninsured, low-income children in your State.

   Indiana commissioned a survey of 10,000 households across the state to collect insurance information on individuals under age 65. The results were then applied to a small area analysis in order to produce estimates of the uninsured at the following levels: block group, census tract, zip code, county, school district, and state House and Senate districts and federal House districts. The results can be used at these local levels to increase enrollment in the targeted areas with low insurance rates.

4. Has your State changed its baseline of uncovered, low-income children from the number reported in your March 2000 Evaluation?

   ___ No, skip to 1.3

   __X__ Yes, what is the new baseline? 57,000 as of June 2000

   A. What are the data source(s) and methodology used to make this estimate?

   A survey of individuals under the age of 65 in Indiana conducted in the first half of 2000 was used as the data source. The state contracted with Health Management Associates to perform this survey. (See Attachment E – Indiana Health Insurance Survey)

B. What was the justification for adopting a different methodology?

The CPS data underestimated the number of uninsured children in Indiana; the program has already enrolled more than 21,000 children above the original estimate and enrollment continues to rise.

C. What is the State's assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

The survey results indicated that 9.4 percent of those surveyed were uninsured. Statistical analyses confirm that the actual percentage is well within +/- 1 percent of the estimate (the actual percentage of uninsured is between 8.4 percent and 10.4 percent).

D. Had your state not changed its baseline, how much progress would have been made in reducing the number of low-income, uninsured children?

We would have enrolled more than 100% of the eligible children.

1.3 Complete Table 1.3 to show what progress has been made during FFY 2000 toward achieving your State's strategic objectives and performance goals (as specified in your State Plan).

In Table 1.3, summarize your State's strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in your SCHIP State Plan. Be as specific and detailed as possible. Use additional pages as necessary. The table should be completed as follows:

Column 1:	List your State's strategic objectives for your SCHIP program, as specified in your State Plan.
Column 2:	List the performance goals for each strategic objective.
Column 3:	For each performance goal, indicate how performance is being measured, and progress towards meeting the goal. Specify data sources, methodology, and specific measurement approaches (e.g., numerator, denominator). Please attach additional narrative if necessary.

Note: *If no new data are available or no new studies have been conducted since what was reported in the March 2000 Evaluation, please complete columns 1 and 2 and enter ANC@ (for no change) in column 3.*

Table 1.3

(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
OBJECTIVES RELATED TO REDUCING THE NUMBER OF UNINSURED CHILDREN		
Uninsured, targeted low-income children will have health insurance as a result of Indiana's Title XXI program.	The CPS conducted in 1999 will show a 10% reduction in the percentage of targeted low-income children who do not have health insurance coverage over the findings of the 1998 results.	Data Sources: Current Population Survey (CPS) Methodology: Original Methodology- Comparison of the reported average of 1995, 1996, and 1997 CPS data with the reported average of 1996, 1997, and 1998 CPS data. Updated Methodology- Comparison of the reported percentage of unduplicated, uninsured children under 200% FPL over the three-year period 1996-1998 against the same group of uninsured children over the three-year period 1997-1999. Progress Summary: Under the original methodology, the CPS suggested that there was a 1.3% reduction in the percentage of targeted low-income children. Under the updated methodology, the CPS suggested that there was an 11.1% reduction in the percentage of targeted low-income children.
OBJECTIVES RELATED TO SCHIP ENROLLMENT		
Uninsured, targeted low-income children will have health insurance through Indiana's Title XXI program.	By September 30, 1999, 40,000 previously uninsured, targeted low-income children will have health insurance through Title XXI.	Data Sources: IndianaAIM (Medicaid Management Information System) Methodology: Based on combined unduplicated count for October 1, 1999 through September 30, 2000. Progress Summary: There were 82,381 children who obtained health insurance through Indiana's Medicaid expansion portion of the Title XXI program at some point between October 1, 1999 and September 30, 2000. Of these, there were 50,473 children enrolled in the program on September 30, 2000. There were 6,534 children who obtained health insurance through Indiana's State-designed program at some point between January 1, 2000 (the beginning of the program) and September 30, 2000. Of these, there were 5,583

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
		children enrolled in the program on September 30, 2000.

OBJECTIVES RELATED TO INCREASING MEDICAID ENROLLMENT		
Children currently eligible but not enrolled in Medicaid will be identified and enrolled in that program.	By September 30, 1999, there will be at least a 10% increase in Title XIX Medicaid enrollment of children under age 19.	Data Sources: NC Methodology: NC Progress Summary: As of September 30, 1999, Title XIX Medicaid enrollment of children under age 19 had increased 38.9 percent since May 31, 1998.
OBJECTIVES RELATED TO INCREASING ACCESS TO CARE (USUAL SOURCE OF CARE, UNMET NEED)		
Children enrolled in Indiana's Title XXI program will have a consistent source of medical and dental care.	By September 30, 1999, 95% of children enrolled in Title XXI will self-select their primary medical provider.	Data Sources: IndianaAIM (Medicaid Management Information System) Methodology: Comparison of auto-assignment rates for September 1999 and June 2000 for all Hoosier Healthwise children as well as Title XXI-specific enrollees. Progress Summary: In June 2000, 7.1% of Hoosier Healthwise members were auto-assigned to a PMP compared to 8.2% in September 1999. In June 2000, 9.8% of Title XXI children were auto-assigned to a PMP compared to 12.7% in September 1999.
OBJECTIVES RELATED TO USE OF PREVENTIVE CARE (IMMUNIZATIONS, WELL-CHILD CARE)		
Children enrolled in Hoosier Healthwise will enjoy improved health status.	By September 30, 1999, measures of health status in place for Hoosier Healthwise will show improvements in the immunization of 2-year olds and preventive health.	Data Sources: NC Methodology: NC Progress Summary: No change in this performance goal. However, additional information on well-child visits for Title XXI children is included in the text immediately following this chart.

OTHER OBJECTIVES		
Parents/children enrolled in Title XXI will be satisfied with the program.	At least 75% of parents surveyed during the first year of their child's participation in the program will express overall satisfaction with the Title XXI program.	Data Sources: 1998 and 2000 Hoosier Healthwise Member Satisfaction Surveys Methodology: Surveys from both years: A random sample of Hoosier Healthwise members were selected from throughout Indiana. The surveys were conducted in either a one-on-one telephone or in-person interview in which each question was read exactly as worded. Responses were recorded and sent to an independent market research organization for data analysis. The survey used two questionnaires: one for the adult population and one for the child population. 1998 Survey: A random sample of 1,505 Hoosier Healthwise members enrolled in September 1998 who had been in the program at least six months. 1999 Survey: A random sample of 1,430 Hoosier Healthwise members enrolled in September 1999 who had been in the program at least six months. Progress Summary: Surveys from both years include children enrolled in Title XIX and in Title XXI. We were unable to obtain Title XXI-specific data. In the 1998 survey, 86% of the members rated the Hoosier Healthwise program as very good or good (using a five-point scale). In the 2000 survey, 84% rated the program very good or good. However, in the 2000 survey, the number rating the program very good jumped to 51% from 45% in the 1998 survey.

OTHER OBJECTIVES		
Providers who participate in the Title XXI program will express satisfaction with the terms and conditions of their participation.	At least 50% of providers surveyed will express overall satisfaction with the Title XXI program.	Data Sources: 1998 and 2000 Hoosier Healthwise Primary Medical Provider Satisfaction Surveys Methodology: Surveys from both years: Questionnaires were distributed to Hoosier Healthwise primary medical providers (PMPs) to be completed by PMPs, office managers and other staff. Competed questionnaires were returned to an independent market research organization for data analysis. 1998 Survey: A total of 1,888 questionnaires were distributed with an overall response rate of 42%. 1999 Survey: A total of 2,148 questionnaires were distributed with an overall response rate of 39%. Progress Summary: PMP satisfaction with the Hoosier Healthwise program continues to increase, from 53% in 1997, 58% in 1998, to 61% in 2000. Those that responded that they were "very satisfied" with the program also increased from 9% in 1998 to 12% in 2000.

OTHER OBJECTIVES		
The child health programs and payment sources in Indiana will be coordinated to achieve family-friendly, seamless systems of care.	The Hoosier Healthwise toll-free Helpline will track system responsiveness and priority issues for parents.	Data Sources: Original Source- Hoosier Healthwise Helpline Monthly Statistics for January through September 1999 Newer Source- Hoosier Healthwise Helpline Monthly Statistics for January through September 2000 Methodology: The number of calls received by the Helpline, the average length per call, the average wait time for calls, and the reasons for the calls were tracked by Hoosier Healthwise staff. Progress Summary: The Hoosier Healthwise Helpline received an average of 3,358 calls per month from January through September 1999 and an average of 5,343 calls per month from January through September 2000 pertaining to Hoosier Healthwise for Children. The average length per call was one minute, forty seconds in the 1999 time period and two minutes, thirty seconds in the 2000 time period. The average wait time per call was one or two seconds in the 1999 time period and one minute, twenty-one seconds in the 2000 time period. In both years, the three most frequent reasons for the calls were eligibility for the program, the annual eligibility redetermination process, and PMP auto-assignment.

Narrative on Selected Objectives

Objective 1: Uninsured, targeted low-income children will have health insurance as a result of Indiana's Title XXI program.

When we first ran this analysis and the CPS suggested only a 1.3% reduction, we were concerned about the low sample size for Indiana in the CPS. The three-year average of the 1996, 1997, and 1998 CPS suggested that there were 123,000 uninsured children in Indiana below 200% of the federal poverty level. Since we had already exceeded this baseline estimate in CPS in our last report, we adjusted the methodology to enlarge the sample size. We did this by aggregating one set of three years' worth of data (1996-1998) and compared this to a second set of three years' worth of data (1997-1999). In both sets of data, duplicate individuals were removed. This new calculation showed an 11.1% decrease in the percentage of targeted low-income children that were uninsured.

Objective 2: Uninsured, targeted low-income children will have health insurance through Indiana's Title XXI program.

Indiana reported that it exceeded the Title XXI enrollment goal of 40,000 previously uninsured, targeted low-income children on the March 2000 evaluation. Since that time period, we have more than doubled our State Plan goal with 82,381 children receiving health insurance through Indiana's Title XXI program at some point in FFY00. This figure includes children who became eligible for Hoosier Healthwise as a result of the 1997 Medicaid expansion to children born before October 1, 1983 with family incomes of no more than 100 percent of the federal poverty level as well as children who became eligible due to the 1998 expansion to 150 percent of the federal poverty level. Despite the fact that older children in Hoosier Healthwise "age out" of the program, Indiana has still exceeded its target of 40,000 with 50,381 children enrolled in the program as of September 30, 2000.

Enrollment in Hoosier Healthwise has increased even further with the expansion of our state-designed program to include children in families with incomes between 150 and 200 percent of the federal poverty level. Since its inception on January 1, 2000, Indiana has enrolled 6,534 children to this program at some point in time during its first nine months of operation.

Objective 3: Children currently eligible but not enrolled in Medicaid will be identified and enrolled in that program.

We reported in our March 2000 evaluation that Indiana far exceeded its goal of increasing Title XIX enrollment for children under age 19. Since last March, we have sustained and, in fact, seen increases in enrollment in this program for children under age 19.

Objective 4: Children enrolled in Indiana's Title XXI program will have a consistent source of medical and dental care.

Our auto-assignment rates for the Hoosier Healthwise program as a whole and for the Title XXI program specifically are continuing to decrease over time. All children enrolled in Hoosier Healthwise select or are assigned to a primary medical provider (PMP) unless the child is a ward of the State, resides in an institution, requires certain level of care, or lives in a medically underserved area that does not have a provider available to serve as the child's PMP. As we reported in our March 2000 evaluation, prior to the Title XXI Medicaid expansion (June 1998), 15 percent of Hoosier Healthwise members were auto-assigned to a PMP. This number has decreased significantly over the last two years to 7.1% in June 2000. For the Title XXI program specifically, the auto-assignment rate decreased 2.9% over a nine-month period, from 12.7% in September 1999 to 9.8% in June 2000.

Indiana continues to target counties where the State wants to increase the number of PMPs serving members. As of September 1999, there were PMPs in all 92 counties in the State. As of September 2000, there were 2,044 PMPs enrolled in Hoosier Healthwise as compared to 1,941 in September 1999 and 1,832 in June 1998. Additionally, there has been a 23% increase in dentists enrolled in Hoosier Healthwise over a two-year period. As of June 2000, there were 1,661 dentists as compared to 1,608 in September 1999 and 1,350 in June 1998.

Objective 5: Children enrolled in Hoosier Healthwise will enjoy improved health status.

We analyzed claims from the IndianaAIM (Medicaid Management Information System) to determine if our newest members to Hoosier Healthwise were receiving well-child care. Specifically, we analyzed children in the Title XXI Medicaid expansion program ages one to six (there are not enough data available yet to analyze our state-designed program). The children included in our Medicaid expansion study are those in families with incomes between 100 and 150 percent of the federal poverty level. We analyzed claims to primary medical providers (PMPs) for those children in the program at least 10 months during the state fiscal year (between July 1, 1999 and June 30, 2000). Our data show that for children age one, more than 85 percent had seen a PMP at least once during the state fiscal year. For children age two, 75 percent had seen a PMP at least once during the state fiscal year. For children at each age group between three and six, at least 65 percent had seen a PMP during the state fiscal year. An analysis was also conducted for the same time period for children in the Title XIX portion of Hoosier Healthwise. This population had even better indicators of well-child care occurring. When we studied the same age groups in Title XIX, for children age one, more than 92 percent had seen a PMP during the state fiscal year. For children age two, the percentage was 85 percent. For children at each age group between three and six, the percentage was at least 75 percent. We will continue to monitor well-child visits for this population as well as the children in our state-designed program as both programs mature.

1.4 If any performance goals have not been met, indicate the barriers or constraints to meeting them.

Nearly all of the performance goals were met in the FFY 1999 report. This year, the only performance goal that has not been met is for Objective 4; **"**Children enrolled in Indiana's Title XXI program will have a consistent source of medical and dental care." The performance goal was that 95% of children enrolled in Title XXI will self-select their primary medical provider.

There are several issues that act as a barrier to meeting this goal. First, if a member does not self-select their primary medical provider within 30 days, then one is assigned to them. The auto-assignment rate, although it continues to decrease, is unnecessarily inflated by members not taking advantage of the opportunity to select their own doctor. Second is the number of providers in the state. While the number of providers is increasing, we are aware of the issues that affect the providers such as reimbursement rates, and we continue to try to address provider supply issues and provider satisfaction issues. (See Attachment F: Provider Satisfaction Survey)

1.5 Discuss your State' s progress in addressing any specific issues that your state agreed to assess in your State plan that are not included as strategic objectives.

N/A

1.6 Discuss future performance measurement activities, including a projection of when additional data are likely to be available.

Indiana will probably revise all of the performance goals for the next annual report since we have met or exceeded all of the goals this year except for one.

1.7 Please attach any studies, analyses or other documents addressing outreach, enrollment, access, quality, utilization, costs, satisfaction, or other aspects of your SCHIP program' s performance. Please list attachments here.

Attachment F- Provider Satisfaction Survey
Attachment G- Member Satisfaction Survey
Attachment H - 4 Steps to CHIP Success
Attachment I – Hoosier Healthwise Performance Update

SECTION 2. AREAS OF SPECIAL INTEREST

This section has been designed to allow you to address topics of current interest to stakeholders, including; states, federal officials, and child advocates.

2.1 Family coverage:

A. If your State offers family coverage, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other program(s). Include in the narrative information about eligibility, enrollment and redetermination, cost sharing and crowd-out. N/A

2. How many children and adults were ever enrolled in your SCHIP family coverage program during FFY 2000 (10/1/99 -9/30/00)?

   Number of adults N/A
   Number of children N/A

3. How do you monitor cost-effectiveness of family coverage? N/A

2.2 Employer-sponsored insurance buy-in:

1. If your State has a buy-in program, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other SCHIP program(s). N/A

2. How many children and adults were ever enrolled in your SCHIP ESI buy-in program during FFY 2000?

   Number of adults N/A
   Number of children N/A

2.3 Crowd-out:

1. How do you define crowd-out in your SCHIP program?
   Crowd out is defined as the entry of applicants into the CHIP program who are eligible for and have access to other (commercial) insurance.

2. How do you monitor and measure whether crowd-out is occurring?
   Crowd-out is monitored by the number of children with commercial health insurance who apply for Hoosier Healthwise. Applicants are required to indicate on the application whether or not they have commercial health insurance. Children who have commercial health insurance may be

eligible for Title XIX Medicaid, but will not be considered for the Title XXI program. Children must be without commercial health insurance for three months before they can be determined eligible for CHIP. Crowd-out is measured by the percentage of children with commercial health insurance who have applied for Hoosier Healthwise.

3. What have been the results of your analyses? Please summarize and attach any available reports or other documentation.

   Since implementation of the 1998 Title XXI Medicaid expansion, there has not been a major change in the percentage of children with commercial health insurance who have applied for Hoosier Healthwise. In May 1998, 11.5 percent of children enrolled in Hoosier Healthwise had other creditable health insurance; in September 1999, 12.9 percent had other creditable health insurance; and in September 2000, 9.2 percent had other creditable health insurance.

4. Which anti-crowd-out policies have been most effective in discouraging the substitution of public coverage for private coverage in your SCHIP program? Describe the data source and method used to derive this information.

   The most effective deterrent appears to be the implementation of the three-month waiting period between private coverage and enrollment into Hoosier Healthwise. Parents are not willing to go without insurance for their children if they are already covered by another source, and so we are effectively covering just those who do not have insurance. Crowd-out has not appeared to have any countable effect on enrollment in Hoosier Healthwise.

2.4 Outreach:

1. What activities have you found most effective in reaching low-income, uninsured children? How have you measured effectiveness?

During FFY 2000, the most effective outreach activity was a television and radio advertising campaign in Spring 2000. The campaign included the Hoosier Healthwise Helpline phone number in a memorable jingle. (An editorial appearing in the May 10, 2000 Chicago Tribune called the jingle "maddeningly indelible.") Calls to the Helpline soared, and the Hoosier Healthwise processing unit for mail-in applications was deluged with a volume 3-4 times normal.

Other highly successful methods of reaching low-income, uninsured children during FFY 2000 included:

- Local enrollment initiatives were pursued by the 92 county offices of the Division of Family and Children (DFC);
- Alternative enrollment options such as mail-in applications and more than 500 enrollment centers throughout the state remained popular alternatives to the local DFC office;
- The State began the second year in a three-year Robert Wood Johnson (RWJ) Covering Kids outreach grant targeting hard to reach populations. Eight local coalitions are

implementing innovations to identify and enroll the hardest to serve populations; and,

- The State continued to contract with three statewide organizations (Indiana Minority Health Coalition, Indiana Black Expo, and the Wishard Hispanic Health Project) to target minority populations across the State.

The effectiveness of the State's outreach efforts is measured in accordance with the number of children who have enrolled. The outreach initiatives have resulted in a Hoosier Healthwise enrollment increase of more than 145,000 children since May 1998. This increase is the clearest evidence that the outreach succeeded in bringing more eligible children into Hoosier Healthwise.

2. Have any of the outreach activities been more successful in reaching certain populations (e.g., minorities, immigrants, and children living in rural areas)? How have you measured effectiveness?

To ensure that minority populations were reached, grants were awarded to three minority community partners to develop specific strategies for underserved populations: the Indiana Minority Health Coalition, Inc., Indiana Black Expo, Inc., and Wishard Health Services' Hispanic Health Project. These organizations have engaged in statewide outreach activities targeting specific minority populations, including the translation and distribution of marketing materials and applications, the coordination of the outreach activities of community organizations, and the organization of media coverage.

Local faith communities are often a trusted source of information for underserved communities. Many local DFC offices and community partners have distributed information to local faith community leaders and have enlisted their help in outreach efforts.

In addition, the radio and TV ads were placed with programming and marketing demographics in mind. Both radio and TV ads were made in Spanish for Latino stations.

3. Which methods best reached which populations? How have you measured effectiveness?

The Hoosier Healthwise enrollment increase is the clearest evidence that the advertising campaign implemented in Spring 2000 was a great success. The development of community-based outreach plans that reflect the unique needs and interests of each county has encouraged the formation of local partnerships which have been vital to the identification of potentially eligible children and the distribution of marketing materials.

The development of specific outreach strategies for traditionally underserved minority populations has also been fundamental to the success of the campaign. By contracting with minority community partners, the State has been able to leverage their understanding of specific minority populations and implement successful, targeted outreach activities.

The State of Indiana believes that a multi-faceted approach is critical to reaching families--using a combination of advertising, community outreach, and by encouraging and supporting one of the most valuable approaches to enrolling families, which is by word of mouth. Marketing the program as insurance has been a factor in the success of the SCHIP program and has lessened the stigma of Medicaid.

One of the reasons that the Helpline jingle was so effective is possibly that it was memorable and could easily be remembered and shared with others. The combination of local outreach strategies with statewide marketing activities has revolutionized the way families access public health services in Indiana.

2.5 Retention:

1. What steps are your State taking to ensure that eligible children stay enrolled in Medicaid and SCHIP?

The State has established a Renewal Task Force to address issue relating to retention and reenrollment in the program. The Task Force has representatives from managed care organizations, providers, and state officials. EP&P Consulting, Inc, the CHIP program's independent evaluation contractor, is also examining enrollment data to illustrate the trends taking place in Indiana's program. (See Attachment J: Analysis of Enrollment Trends in the Hoosier Healthwise Program)

2. What special measures are being taken to reenroll children in SCHIP who disenroll, but are still eligible?

__X__ Follow-up by caseworkers/outreach workers
__X__ Renewal reminder notices to all families
____ Targeted mailing to selected populations, specify population _____
____ Information campaigns
____ Simplification of re-enrollment process, please describe _____
____ Surveys or focus groups with disenrollees to learn more about reasons for disenrollment, please describe_____
____ Other, please explain_____

3. Are the same measures being used in Medicaid as well? If not, please describe the differences.

Yes, the reenrollment process is the same for both the Medicaid and SCHIP enrollees.

4. Which measures have you found to be most effective at ensuring that eligible children stay enrolled?

At this time, we have just begun to assess renewal/reenrollment and have not yet determined the most effective methods for ensuring that eligible children stay enrolled. However, we have established a Renewal Task Force to examine these issues.

5. What do you know about insurance coverage of those who disenroll or do not reenroll in SCHIP (e.g., how many obtain other public or private coverage, how many remain uninsured?) Describe the data source and method used to derive this information.

   At this time, we do not collect this type of information upon disenrollment.

2.6 Coordination between SCHIP and Medicaid:

1. Do you use common application and redetermination procedures (e.g., the same verification and interview requirements) for Medicaid and SCHIP? Please explain.

   Yes, SCHIP was built upon the existing infrastructure of the Medicaid program and therefore uses the same application and procedures. We have found this to be of the utmost usefulness since families in this income range fluctuate between the two programs. As a result, children in Indiana always have coverage, regardless of the program from which they are funded.

2. Explain how children are transferred between Medicaid and SCHIP when a child's eligibility status changes.

   When a child's eligibility status changes, the Indiana Client Eligibility System (ICES) assigns a new eligibility code to that child. This file is updated daily and therefore updates with other interfacing systems seamlessly. By building the SCHIP program upon the existing infrastructure of Medicaid, we eliminated any pitfalls that would occur when a child moves between the two programs.

3. Are the same delivery systems (including provider networks) used in Medicaid and SCHIP? Please explain.

   As mentioned above, CHIP is based on the same infrastructure as Medicaid. As a result, in order to be a provider for SCHIP, one must also agree to provide coverage to Medicaid eligibles, and vice versa. This has been an essential part of our success in keeping children enrolled as their family income changes. (See Attachment – 4 Steps to Success in Indiana.)

2.7 Cost Sharing:

1. Has your State undertaken any assessment of the effects of premiums/enrollment fees on participation in SCHIP? If so, what have you found?

   Since the state-designed program just began in January 2000, we are only now starting to think that there are enough data to do some preliminary analyses. However, Indiana offers members the option to pay the premiums either monthly, quarterly, or annually and we have been very surprised and encouraged by the number of members who pay the premiums annually. This is an indication that the premium amount may not be a barrier to enrollment.

2. Has your State undertaken any assessment of the effects of cost-sharing on utilization of health service under SCHIP? If so, what have you found?

   Again, since the program is still ramping up, we have not performed any formal evaluation of the cost-sharing on utilization yet. However, the copayments are minimal and are only on ambulance transportation and drugs, so the effect is likely to be negligible. Copayments for Package C are as follows: $10 for ambulance transportation, $3 for generic, compound, or sole-source drugs, $10 for brand name drugs

2.8 Assessment and Monitoring of Quality of Care:

1. What information is currently available on the quality of care received by SCHIP enrollees? Please summarize results.

   The managed care organizations are currently using HEDIS measures to track quality of care received by their members. Prior to using HEDIS, quality was measured using state-designed focus studies. These are reported in the March 2000 evaluation. The results from HEDIS 2000 are not available at the time of this evaluation. The managed care organizations will use eleven measures to track quality of care for HEDIS 2001.

2. What processes are you using to monitor and assess quality of care received by SCHIP enrollees, particularly with respect to well-baby care, well-child care, immunizations, mental health, substance abuse counseling and treatment and dental and vision care?

   In the past, Indiana has used focused studies, client satisfaction survey, and complaint and grievance reviews to assess quality in the Hoosier Healthwise population. Starting with calendar year 2000, the State began using HEDIS measures instead of state-designed measures to facilitate comparisons across the managed care delivery systems. The results from this first HEDIS study are not yet available.

3. What plans does your SCHIP program have for future monitoring/assessment of quality of care received by SCHIP enrollees? When will data be available?

   Indiana has contracted with EP&P Consulting, Inc. to perform an independent evaluation of the program. This report will be presented to the legislature in April 2001. Also, for calendar year 2001, the state will increase the number of HEDIS measures used to track quality of care.

SECTION 3. SUCCESSES AND BARRIERS

This section has been designed to allow you to report on successes in program design, planning, and implementation of your State plan, to identify barriers to program development and implementation, and to describe your approach to overcoming these barriers.

3.1 Please highlight successes and barriers you encountered during FFY 2000 in the following areas. Please report the approaches used to overcome barriers. Be as detailed and specific as possible.

Note: If there is nothing to highlight as a success or barrier, Please enter "NA" for not applicable.

1. Eligibility - While Indiana has had great success in enrolling children below 150% FPL, we have experience slower growth in enrollment above 150% FPL than anticipated. We would also like to be more successful in enrolling teens since our survey indicates we have a disproportionate number of Hoosier Healthwise eligible teens uninsured.

2 & 3. Outreach and Enrollment - Key to the enrollment success is that Indiana is changing the perception of Medicaid and SCHIP from public assistance to health insurance by:

Mainstreaming the Image: Medicaid/CHIP was renamed "Hoosier Healthwise" and is referred to as "insurance". It has various plans much like commercial plans, such as Package A (formerly Medicaid and Phase I of SCHIP) and Package C (Phase II of SCHIP). We have changed the way we talk and think about publicly funded health insurance:

- We no longer talk about "Medicaid" but about Hoosier Healthwise.
- The insurance is "affordable", not "free".
- Those who participate are referred to as "members", not "recipients".
- Provider materials and training have been changed to reflect the language of "members" and "medical services" rather than "recipients" and "public assistance".

Simplifying Enrollment: Complicated forms have been eliminated and families do not have to go to local offices to apply.

- Families apply for either Medicaid or SCHIP by using a single Hoosier Healthwise application that was simplified and shortened to a 1 page, front/back form.
- Indiana established nearly 500 enrollment centers and provided mail-in applications with telephone interviews.

Managing By Results: Every local Division of Family and Children (DFC) Office was required to submit an outreach plan for meeting its target, was given funding through the Personal Responsibility and Work Opportunity Recognition Act of 1996 (PRWORA) to implement its plan, and was held accountable for the results.

Locally Based Outreach: The county enrollment plans are county-specific and grass-roots,

tailored to the local culture and demographics.

Developing Minority Outreach: Targeted campaigns reach out to minority populations.

Developing Family- and Provider-Friendly Systems: Children move between programs effortlessly.

- Because local offices have Hoosier Healthwise enrollment targets, case workers are eager to enroll children, creating a friendlier environment for families than they may have met in earlier days.
- Indiana is building its SCHIP on the same Medicaid outreach, enrollment, provider, and claims reimbursement systems. This results in programs that are seamless to families and to providers, and prevent a two-tiered system of care.
- The old institutional-looking card which reads "Indiana Medicaid and Other Medical Assistance Programs" was replaced with a new colorful card, resembling any commercial insurance card.

Training Caseworkers, Benefit Advocates, and Providers: Caseworkers, enrollment center workers, benefit advocates, and providers were trained.

- Through extensive efforts, provider manuals, banners and bulletins, and promotional materials are being re-written.
- Provider cooperation was recruited through extensive statewide training that gave providers and their office staffs information about the new approaches the State is taking to de-stigmatize Medicaid.

Note: Indiana used PRWORA to fund outreach.

It is important to note that the legislature, now facing a large Medicaid forecast, is expressing concern about the Hoosier Healthwise enrollment success.

4. Retention/disenrollment - Approximately 1% of children disenroll each month from Hoosier Healthwise. Without comparative information, the success or lack of success in this area is difficult to assess, though we are trying to do that. Regardless, a Renewal Task Force is developing ways to decrease disenrollment, when appropriate.

5. Benefit structure - The Package C benefit package is richer than it otherwise might have been, however lobbyists for chiropractors and podiatrists prevailed in their efforts to have additional benefits covered in Package C.

6. Cost-sharing - While some argue that families want to pay premiums, a study to determine whether premiums are an enticement to enrollment or a barrier to enrollment would be helpful.

7. Delivery systems - Building the state-designed portion of SCHIP on the same infrastructure as Medicaid and the first phase of SCHIP has several advantages:

- Families and providers move seamlessly between Medicaid and SCHIP.
- SCHIP leveraged many changes in Medicaid.
- By marketing SCHIP and Medicaid as Hoosier Healthwise, Medicaid lost much of its stigma. One parent told a national reporter that Medicaid was awful but Hoosier Healthwise is great!!

8. Coordination with other programs – Developing SCHIP provided many opportunities for coordination with other programs. An example of this coordination is that the Package C benefit package was designed to serve more children by using the state's Children's Special Health Care Services as wrap-around for special needs children.

9. Crowd-out - The waiting period is a barrier to some families, especially farm families. They must keep catastrophic insurance because, in case of an accident or major medical problem, they would lose their farm. On the other hand, sometimes they cannot afford any preventive care for their children.

10. Other - SCHIP captured the hearts of many. The unusual bipartisan consensus around this program has created coalitions and partners who take a very personal interest in the success of Hoosier Healthwise. Many people have dedicated countless volunteer hours, helping to design, implement, do outreach and enrollment, and evaluate the program.

SECTION 4. PROGRAM FINANCING

This section has been designed to collect program costs and anticipated expenditures.

4.1 Please complete Table 4.1 to provide your budget for FFY 2000, your current fiscal year budget, and FFY 2002 projected budget. Please describe in narrative any details of your planned use of funds.

Note: Federal Fiscal Year 2000 starts 10/1/99 and ends 9/30/00).

	Federal Fiscal Year 2000 costs	Federal Fiscal Year 2001	Federal Fiscal Year 2002
Benefit Costs			
Insurance payments			
Managed care*	$9,758,000	$12,377,000	$15,261,000
per member/per month rate X # of eligibles			
Fee for Service**	$55,805,000	$75,633,000	$98,683,000
Total Benefit Costs	$65,562,000	$88,010,000	$113,944,000
(Offsetting beneficiary cost sharing payments)	-$194,000	-$1,435,000	-$2,665,000
Net Benefit Costs	$65,368,000	$86,575,000	$111,279,000
Administration Costs			
Personnel	$2,141,000	$2,227,000	$2,327,000
General administration	$25,000	$35,000	$40,000
Contractors/Brokers (e.g. enrollment contractors)	$2,731,000	$3,200,000	$3,520,000
Claims Processing	$683,000	$921,000	$1,060,000
Outreach/marketing costs	$50,000	$50,000	$50,000
Other	$3,858,000	$1,850,000	$1,693,000
Total Administration Costs	$9,488,000	$8,283,000	$8,690,000
10% Administrative Cost Ceiling	$7,263,000	$9,619,000	$12,364,000
Federal Share (multiplied by enhanced FMAP rate)	$54,809,000	$69,655,000	$88,094,000
State Share	$20,046,000	$25,204,000	$31,876,000
TOTAL PROGRAM COSTS	$74,856,000	$94,858,000	$119,969,000

*Managed care includes all capitation payments paid to MCOs.

**Fee for service category includes services for those members who are in FFS before selecting a PMP, and also includes the services for members who are in PCCM. This category also contains the $3 per member per month fee to PCPs.

4.2 Please identify the total State expenditures for family coverage during Federal fiscal year 2000.

N/A

4.3 What were the non-Federal sources of funds spent on your CHIP program during FFY 2000?

__X__ State appropriations – TOBACCO SETTLEMENT FUNDS
_____ County/local funds
_____ Employer contributions
_____ Foundation grants
_____ Private donations (such as United Way, sponsorship)
_____ Other (specify) _____

A. Do you anticipate any changes in the sources of the non-Federal share of plan expenditures.

No. The appropriation from the State is determined every two years through the biennium budget set by the Legislature. The Legislature is currently in session and will set the 2002-2003 appropriations for CHIP from the tobacco settlement fund.

SECTION 5: SCHIP PROGRAM AT-A-GLANCE

5.1 To provide a summary at-a-glance of your SCHIP program characteristics, please provide the following information. If you do not have a particular policy in-place and would like to comment why, please do. (Please report on initial application process/rules)

Table 5.1	Medicaid Expansion SCHIP program	Separate SCHIP program
Program Name	*Hoosier Healthwise – Package A*	*Hoosier Healthwise – Package C Children's Health Plan*
Provides presumptive eligibility for children	___X__No _____Yes, for whom and how long?	__X___No _____Yes, for whom and how long?
Provides retroactive eligibility	_____No ___X___Yes, for whom and how long? *Benefits are retroactive up to 3 months for those who are determined to be eligible.*	_____No ___X___Yes, for whom and how long? *Benefits are retroactive back to the first day of the month of application, once the first premium has been paid.*
Makes eligibility determination	___X___State Medicaid eligibility staff _____Contractor _____Community-based organizations _____Insurance agents _____MCO staff _____Other *(specify)* _____	___X___State Medicaid eligibility staff _____Contractor _____Community-based organizations _____Insurance agents _____MCO staff _____Other *(specify)* _____
Average length of stay on program	Specify months: *The average length of stay is 7 months out of a possible 12 months for those members enrolled in the program in FFY 2000.*	Specify months: *This information could not be calculated since the separate program was not in existence the entire FFY 2000. (Program implemented on 1/1/2000.)*
Has joint application for Medicaid and SCHIP	_____No __X___Yes	_____No ___X___Yes
Has a mail-in application	_____No ___X___Yes	_____No ___X___Yes
Can apply for program over phone	_____No __X___Yes	_____No __X___Yes
Can apply for program over internet	__X___No	___X___No

Table 5.1	Medicaid Expansion SCHIP program	Separate SCHIP program
	_____Yes	_____Yes
Requires face-to-face interview during initial application	___X___No _____Yes	___X___No _____Yes
Requires child to be uninsured for a minimum amount of time prior to enrollment	___X___No _____Yes, specify number of months _ What exemptions do you provide?	_____No ___X___Yes, specify number of months 3 months What exemptions do you provide? *An exemption is provided if the family has an involuntary loss of coverage (loss of job, etc) or if the child was previously covered by Medicaid.*
Provides period of continuous coverage <u>regardless of income changes</u>	_____No ___X___ Yes, specify number of months ___12___ Explain circumstances when a child would lose eligibility during the time period. *A child would lose eligibility if he/she moved out of state, or turned age 19.*	_____No ___X___Yes, specify number of months ___12___ Explain circumstances when a child would lose eligibility during the time period. *A child would lose eligibility if the premium is not paid, if the child moves out of state, if the child is included under a private insurance plan that is considered creditable, or if the child turned age 19 during the year.*
Imposes premiums or enrollment fees	___X___No _____Yes, how much? _____ Who Can Pay? ___ Employer ___ Family ___ Absent parent ___ Private donations/sponsorship ___ Other (specify) _____	_____No ___X___Yes, how much? _____ Who Can Pay? ___ Employer _X_ Family ___ Absent parent ___ Private donations/sponsorship _X_ Other (specify) Guardian
Imposes copayments or coinsurance	___X___No _____Yes	_____No ___X___Yes
Provides preprinted redetermination process	___X___ No _____ Yes, we send out form to family with their information precompleted and: ___ ask for a signed confirmation that information is still correct ___ do not request response unless	___X___ No _____ Yes, we send out form to family with their information and: ___ ask for a signed confirmation that information is still correct

Table 5.1	Medicaid Expansion SCHIP program	Separate SCHIP program
	income or other circumstances have changed	___ do not request response unless income or other circumstances have changed

5.2 Please explain how the redetermination process differs from the initial application process.

(See Attachment K: Policy Memo on Hoosier Healthwise Redetermination Guidelines)

SECTION 6: INCOME ELIGIBILITY

This section is designed to capture income eligibility information for your SCHIP program.

6.1 As of September 30, 2000, what was the income standard or threshold, as a percentage of the Federal poverty level, for countable income for each group? If the threshold varies by the child=s age (or date of birth), then report each threshold for each age group separately. Please report the threshold after application of income disregards.

Title XIX Child Poverty-related Groups or Section 1931-whichever category is higher	150% of FPL for children under age 1 133% of FPL for children aged 1 through 5 100% of FPL for children aged 6 through 18
Medicaid SCHIP Expansion	150% of FPL for children aged 1 through 18 ____% of FPL for children aged _____ ____% of FPL for children aged _____
State-Designed SCHIP Program	200% of FPL for children aged 1 through 18 ____% of FPL for children aged _____ ____% of FPL for children aged _____

6.2 As of September 30, 2000, what types and *amounts* of disregards and deductions does each program use to arrive at total countable income? *Please indicate the amount of disregard or deduction used when determining eligibility for each program. If not applicable, enter ANA.@*

Do rules differ for applicants and recipients (or between initial enrollment and redetermination) ____ Yes X No
If yes, please report rules for applicants (initial enrollment).

Table 6.2

	Title XIX Child Poverty-related Groups	Medicaid SCHIP Expansion	State-designed SCHIP Program
Earnings	$90	$90	$90
Self-employment expenses	40% of gross income	40% of gross income	40% of gross income
Alimony payments Received	$0	$0	$0
Paid	$0	$0	$0
Child support payments Received	$50	$50	$50
Paid	$0	$0	$0
Child care expenses	$200 if child is under 2 years of age. $175 if child is 2 years of age or older	$200 if child is under 2 years of age. $175 if child is 2 years of age or older	$200 if child is under 2 years of age. $175 if child is 2 years of age or older
Medical care expenses	$0	$0	$0
Gifts	$0	$0	$0
Other types of disregards/deductions (specify)	$0	$0	$0

6.3 For each program, do you use an asset test?

Title XIX Poverty-related Groups	X No	____Yes, specify countable or allowable level of asset test_____
Medicaid SCHIP Expansion program	X No	____Yes, specify countable or allowable level of asset test_____
State-Designed SCHIP program	X No	____Yes, specify countable or allowable level of asset test_____
Other SCHIP program_____	____No	____Yes, specify countable or allowable level of asset test_____

6.4 Have any of the eligibility rules changed since September 30, 2000? ___ Yes X No

SECTION 7: FUTURE PROGRAM CHANGES

7.1 What changes have you made or are planning to make in your SCHIP program during FFY 2001 (10/1/00 through 9/30/01)? Please comment on why the changes are planned.

1. Family coverage –The Children's Health Policy Board established the Health Insurance for Indiana Families (HIIF) Committee in 2000 to investigate strategies for extending health care coverage to uninsured Indiana citizens. The Board charged the Committee to consider various policy alternatives and to develop proposals for short- and long-term policy options. The committee members reflected the interests and concerns of many groups, including uninsured citizens, small businesses, insurers, medical educators, state officials, and health care providers. With input from this Committee as a catalyst for new ideas, Indiana currently has pending legislation that would allow expansion to cover parents of enrolled children.

2. Employer sponsored insurance buy-in – The HIIF Committee discussed employer-sponsored insurance initially, but agreed that it could not be accomplished in the short-term. It may be included in future Committee discussions of long-term options.

3. 1115 waiver – If necessary, we may seek an 1115 waiver in order to expand coverage to parents of SCHIP children. In addition, we will seek the necessary HCFA approval – including 1115 waivers when appropriate – in order to fund public health projects with the redistributed funds we receive in FFY 2001 and 2002.

4. Eligibility including presumptive and continuous eligibility – At this time, Indiana does not plan to pursue presumptive or continuous eligibility.

5. Outreach - Currently, Indiana is not planning a massive outreach campaign for the upcoming year. However, we will continue to address opportunities to target the hard to reach populations. Mechanisms to use the school lunch program as an entry point are being pursued.

6. Enrollment/redetermination process – The Renewal Task Force will continue to meet in FFY 2001 with the goal of better understanding the barriers in the redetermination process and implementing ways to eliminate these barriers.

7. Contracting – At this time, there are no significant changes planned for contractors to the SCHIP program.

1. Other – The State has plans to develop and refine evaluation, especially of utilization for the newly developed state-designed program, for decision-making purposes. Also, as more information becomes available from the census, we also hope to refine our application of the survey results to more updated CPS estimates. Lastly, the following outlines tentative plans for improving the health of Hoosier children through the redistributed funds, subject to HCFA approval. (See Attachment L- Potential Options for Redistributed CHIP Funds)